

THE

BOSTON MEDICAL AND SURGICAL JOURNAL.

NEW SERIES.]

THURSDAY, DECEMBER 26, 1872.

[VOL. X.—No. 26.]

Original Communications.

INTESTINAL HÆMORRHAGE IN TYPHOID FEVER.

Read before the Providence Medical Association,
Nov. 4, 1872.

By CHARLES W. PARSONS, M.D.,
Providence, R. I.

THE death of Dr. Lyman L. Swan, a valued member of this Association, gives a particular and melancholy interest to the disease and the special symptom by which he died. At the meeting held in respect for his memory on the 23d of September, it was mentioned that after being somewhat unwell for a few days, he walked about and packed his carpet-bag, on Monday the 9th of September, made arrangements for an expected illness, and took to his bed that day. Dr. Brown, who attended him with great fidelity, had a few years before seen him through an attack of mumps, which was accompanied by so much prostration and delirium as to be alarming. He knew, also, that Dr. Swan had been working hard in his profession, and had had extra fatigue and anxiety on account of the sickness and death of a brother, from heart-disease, at the country homestead some nine miles distant. Anticipating a serious attack, Dr. Brown called in Dr. Collins, who visited constantly in consultation, beginning on Wednesday, September 11th. Dr. Swan early showed great weakness, especially by the voice, which was husky or whispering. He had not much delirium, less throughout this disease than with the mumps. He was rather constipated at first, took some aperient medicine, and never had any great diarrhœa.

In the night succeeding Thursday, Sept. 19th, ten days after his illness may be considered to have begun, he had his first hæmorrhage from the bowels. This occurred again, very profusely, toward noon

of next day. These repeated losses of blood rapidly exhausted his strength; but his intellect was little impaired; after this excessive hæmorrhage, he executed his will. His voice returned to some extent that evening; but his strength and pulse did not, and he died about 2 A.M., Saturday, September 21st. If we date his typhoid fever from the time when he took to bed, on which same day he had been walking in the street, then he had entered on the twelfth day of his disease. He was nearly 34 years old.

From the interest we all feel in this case, personally and professionally, I have been led to look up the recorded experience of physicians who have seen much of typhoid fever, and seek an answer to some questions that occur in relation to this symptom of hæmorrhage from the bowels.

I. The frequency of this symptom in typhoid fever varies a good deal in the experience of different observers. Doubtful diagnosis may explain part of this diversity, but not all.

No reports in the English language have thrown more light on the natural history of continued fevers than Dr. (now Sir William) Jenner's. At the London Fever Hospital, in the years 1847-49, when typhus spread from Ireland to Great Britain and the United States, he collected nearly 2000 accurate reports of cases. After separating cases of relapsing fever, he selects from the others those fatal cases of which the diagnosis had been confirmed by autopsy. There were 66 such cases and records of *post-mortem* examinations. Of these, 23 presented the intestinal and mesenteric lesion—the anatomical sign of typhoid fever—43 did not present it. The two groups were named by him typhoid and typhus, the distinction being based on these *post-mortem* appearances. They presented marked differences in their history, "so different, indeed, as to render their separation a matter of absolute necessity, if accuracy was to be maintained in the descrip-

tion of these diseases, or certainly arrived at in their treatment." The typhoid cases (or those where the lesion referred to did exist) were all under 40 years old; nearly one-third of the others were over 50; the average duration of the fatal cases was, in the first group, 22 days; in the second, 14; the eruption was, according to Jenner, as different in the two sets of cases "as well could be, considering that both were of a reddish hue." Other distinctions show that these fever cases make two groups, generally unlike in important points, though these may run into one another. Now, in 15 of the typhoid cases where the presence or absence of epistaxis is mentioned, it occurred in 5 (or one-third); in 23 cases of typhus it occurred in none. And Jenner's report states that hæmorrhage from the bowels occurred in one-third of the cases he calls typhoid, in not one of the typhus. Only one of the typhus patients in three years had discharge of blood from the bowels, and that was an old man with hæmorrhoids.

Dr. John B. S. Jackson, for many years the leading morbid anatomist of Boston, reports in this JOURNAL, Aug. 8th, 1872, 43 fatal cases of typhoid, of which he had some notes of the *post-mortem* appearances. In 5 of these, hæmorrhage from the bowels was considered the cause of death.

Of 303 cases of typhoid, at the Massachusetts General Hospital, analyzed by Dr. James Jackson, 31 presented this symptom. Flint observed it in 3 out of 73 cases that he analyzed. This autumn there have been 12 cases in the Rhode Island Hospital; two had hæmorrhage.

At the Hotel Dieu, in Paris, Louis observed 46 fatal cases, which are analyzed in his treatise on Fever, and of which he considered the diagnosis made out. Of these, only two presented this symptom, and one of these (observation xlv.) ranked by him as latent typhoid, was a tubercular case, the record of which, as he gives it, reads very much like acute tuberculosis. He speaks of three cases of this hæmorrhage in typhoid—in each repeated for a few days—and followed by recovery.

Chomel, at the same hospital, observed this hæmorrhage during life in 5 out of 42 fatal cases, and concealed hæmorrhage within the small intestines, ascertained after death, in one more.

All these statements must be considered as referring to adults, or those past the age of puberty. In the typhoid of children, hæmorrhage appears to be rare. Rilliet and Barthéz, in their great work on Dis-

eases of Children, give no instance of it in 111 cases of the disease. They quote one at the age of 14, a fatal case, observed by M. Taupin.

We cannot make any general statement from these figures, as to the proportion of cases of typhoid in which hæmorrhage from the bowels occurs. Adding up the whole list of *fatal* cases, observed in London, Paris and this country, we find that this symptom was present in about $\frac{1}{4}$ of these fatal cases (or 1 in 7.7). Adding up the cases, fatal or not, observed by Jackson and Flint in this country, and at our hospital this autumn, we find that it occurred in about $\frac{1}{11}$ of all, or 1 in 10.77 (cases below the age of 15 excluded).

As hæmorrhage may sometimes be overlooked, where the dejections are not constantly examined by the physician, its frequency is liable to be understated rather than exaggerated. Some allowance ought also to be made for cases of concealed hæmorrhage. I have alluded to such a case reported by Chomel. Andral relates the history of a man, aged 28, who had had diarrhoea three weeks before entering the hospital, lived in hospital 18 days, growing weaker, but passing no blood. After death, it was found that the lower two-thirds of the small intestine were filled with dark blood, much clotted; none had passed the ileo-cæcal valve.

II. As to the *fatality* of this accident, or its influence on the mortality of the disease, it is difficult to get adequate statistical evidence. The interest taken in the morbid anatomy of typhoid fever has drawn special attention to fatal cases, especially in the clinical reports of the earlier French observers. I had supposed that this symptom was one of very grave import, and have been surprised at the amount of testimony to the opposite effect given by physicians of very large experience.

Of 6 cases reported by Flint, 5 recovered, though in one the hæmorrhage was so profuse as to cause syncope and loss of pulse at the wrist for several hours.

Of Dr. Jackson's 31 cases at the Massachusetts General Hospital, 20 ended favorably.

He remarks, in his report on cases observed at that hospital, from 1821 to 1835, "In some instances, the hæmorrhage was followed by relief, and in a few by well-marked and permanent relief. But in most, there was great weakness and sense of exhaustion in consequence of it."

Dr. Sutton, of Kentucky, in a paper on this disease, says he remembers 10 cases where hæmorrhage occurred, and death

followed in only 2; and in a note he adds, "Since writing the above, I have seen several other cases, but no death." Dr. Elisha Bartlett says that he had seen as many cases end in recovery as in death. The two recent patients at our hospital both recovered.

Graves, Trousseau and Austin Flint, three physicians of great experience, representing Ireland, France and this country, agree that, though hæmorrhage is sometimes directly fatal, and sometimes helps to induce fatal prostration, still it does not, on the whole, add materially to the fatality of typhoid fever. Trousseau does not give the number of his cases, but quotes three where recovery followed copious hæmorrhages, as well as three illustrative cases of death which he had seen within seven years. In one, the bleeding occurred on the 12th day, a large quantity of dark, fluid, very fetid blood being passed; it was repeated the next day; from that time the symptoms became sensibly less severe; the patient was convalescent in about a month from the beginning of the disease. In another, three large, bloody dejections occurred on the 24th day; "immediately after, I observed a marked improvement; in the evening, it was noted that the fever was moderate, that there was no abnormal heat, that there was an appearance of greater comfort, and a desire for food." Next day, "the pulse, till then above 120, had come down to 80." Three days later, there was again interstitial hæmorrhage, with epistaxis. Speedy recovery followed. The case reminds one of a remark of Sir Henry Holland, that hæmorrhage sometimes forms a crisis to this disease.

The French physicians who taught in the Paris hospitals more than twenty-five years ago regarded this symptom as a very grave one. Chomel said, in his lectures: Of 7 cases where these hæmorrhages were observed at Hotel Dieu, in 6 the disease was fatal; one recovered after large loss of blood. But the death is not commonly the immediate effect of this loss; of the 6, in only one was death notably hastened by bleeding.

I am afraid that this difference in results was partly owing to treatment. A large part of Chomel's patients were bled very soon after entering the hospital, when they had in most instances been sick already some days. For high fever or delirium, leeches behind the ears were frequently ordered afterward. The published cases do not show that these symptoms were re-

lieved by taking blood. The diet was meagre.

The extent to which this depleting practice was sometimes carried, and the effects it produced, may be illustrated by these remarks of M. Andral, in a debate at the Academy of Medicine: "At one period of my medical life, I, too, used to bleed very largely [in typhoid fever]. I made not less than three, four or five abundant bleedings, near to one another, and to some individuals I had not less than two hundred leeches applied, for I was convinced it was necessary to attack congestion wherever I saw signs of it. Do not ask me what were the results of this practice. Habitually, after large bleedings, I saw the nervous symptoms increased, subsultus more marked, delirium more unyielding, and hæmorrhages more frequent. I may say the same of pneumonia. I have seen patients who, after one or two bleedings, fell into prostration, breathing became more labored and noisy, expectoration was suppressed and death ensued. I may say the same of erysipelas, &c."

There is some reason to think that the fatality of this accident increases with advancing years. In 22 cases of hæmorrhage, where the age was noted, the average age of the 9 who recovered was 24 $\frac{6}{10}$ years; of the 13 who died, 29 $\frac{4}{10}$, a difference of nearly five years.

III. Intestinal hæmorrhage may take place at very various periods in the course of typhoid fever. The earliest appearance of it that I have seen recorded is in the following, from Andral: "The person had been sick only three days, and for that time had a febrile movement with not very strongly marked symptoms, when, suddenly, after some griping pains, he passed at one time more than a quart of blood. After this, he had a prolonged syncope. . . . The hæmorrhage was not repeated, and the patient went through the usual course of a typhoid fever, which ended favorably."

Todd gives two cases, one occurring on the 5th, and one on the 7th day after the date from which the fever might be considered to have begun. Both patients recovered. Each lost about a pint at one time; and in one, blood continued to pass. Both were very much prostrated afterwards.

Including these, I have represented in the following table the date of first appearance of hæmorrhage in 26 cases, half of which were fatal. Of course, the beginning of the fever often cannot be determined to a day.

Day of fever when hæmorrhage first appeared.	Recovered.	Fatal.	Total.
3d-8th (or 1st week)	3	0	3
9th-15th (or 2d week)	4	4	8
16th-22d (or 3d week)	3	5	8
23d-29th (or 4th week)	2	4	6
32d	1	0	1
	13	13	26
Before end of 2d week,	7	4	11
After beginning of 3d week,	6	9	15

IV. This inquiry as to the period at which this symptom may occur leads us to ask on what *local conditions* it may depend. The leading features in the morbid anatomy of typhoid are well known. Rokitsansky describes them as presenting four stages, which may be briefly indicated as follows:

1. Congestion in the mucous membrane.
2. Swelling of the glands, which he speaks of as typhus infiltration or deposit, in which period congestion retreats to, and becomes localized in or around the gland-patches.
3. Softening and elimination, when the labor of throwing off the local results of disease produces a new or secondary congestion, the vessels of the mucous membrane becoming filled with dark and viscid blood.
4. Ulceration.

Sometimes the glands slough and are thrown off in mass, involving a variable depth. In the Warren Anatomical Museum is a specimen, showing ulceration of Peyer's patches just above the ileo-cæcal valve, and a small slough hanging from one of them. Blood was found in the intestine below the slough, but none above. This man died about an hour and a half after symptoms of internal hæmorrhage began, having meantime had a profuse discharge of blood.

Here, then, are three conditions of the mucous membrane in this disease, either of them liable to cause bleeding, intense congestion, ulceration, occasionally sloughing. We might suppose that bleeding would be less dangerous, more likely even to be salutary, in the congestion preceding ulceration, and the few facts just given in the table tend to confirm that idea. In some cases—it is impossible to say how many—hæmorrhage is probably a natural relief to the overloaded vessels, analogous to epistaxis.

When the death of Dr. Swan, on the 12th day of his fever, was related, I thought it was too early for ulceration probably to have begun. But a reference to recorded cases shows the truth to be otherwise. Murchison, of London, says ulceration generally begins about the 9th or 10th day.

The earliest autopsy of typhoid fever I

have read of was by Chomel, the patient having died on the 7th day. The man was 22 years old, attacked Jan. 16th, entered hospital Jan. 20th; had had headache, fever, diarrhoea, and was attacked that night with violent delirium; 21st, had delirium, full, hard pulse of 110; dry tongue, sordes on teeth, rosamina. Was bled. Next day was in muttering delirium; had ceased to answer questions; tongue and teeth in yet worse state; no diarrhoea; involuntary discharges of urine. Twelve leeches behind each ear were ordered; they bled freely, and that evening he died. Several elliptical patches were found, swollen so as to project into the cavity of the bowel, some near the valve even pediculated or mushroom shaped. The projecting patches were pale, the mucous membrane around them very red, in some places livid. There was no ulceration.

Louis gives three autopsies of death on the 8th day. Two presented slight ulceration near the valve—in one near the centre of the patch nearest the valve, in one occupying solitary glands. The third had some thinning of mucous membrane over thickened patches, but it was nowhere quite destroyed. In an autopsy of the 10th day, there were some ulcers two or three lines broad. One patient died of perforation the 14th day.

Chomel gives nine autopsies of deaths within the second week. Of these, 4 presented no ulceration; two of these deaths were on the 8th, one the 11th, one the 12th day. Five did have them; these died, one on the 9th, one the 10th, two the 12th, one the 13th day.

Dr. J. B. S. Jackson says that in one of his autopsies, ulceration had not begun on the 17th day.

On the whole, then, if Dr. Swan died of hæmorrhage with ulceration on the 12th day, there was nothing extraordinary in it.

V. Finally, on the practical questions of *diagnosis* and *treatment*, I have only two remarks to make.

In concealed hæmorrhages, or before blood appears externally, bleeding may sometimes be suspected from sudden weakness, paleness or sinking, not explained by diarrhoea, nor accompanied by the pain of perforation. The temperature is often remarkably lowered; in two cases mentioned by Dr. E. A. Parkes, sinking to 93° at morning. Niemeyer remarks, "Hæmorrhages, if abundant, often betray themselves before the appearance of blood in the dejections, by the collapse of the patient, accompanied by a sudden fall of his tem-

perature, and occasionally by a clearing of the intellect."

The oil of turpentine has served me, as it has many physicians who have written on typhoid fever, better than the ordinary astringents in checking this hæmorrhage.

AGORAPHOBIA AGAIN.

By S. G. WEBER, M.D. HARV.

EXCEPT that a very able article on this subject has just been published in the *Archiv f. Psychiatrie und Nervenkrankheiten*, vol. iii. 3, containing an analysis of 29 cases, I should not have referred to this subject again.

Dr. Williams considers this symptom simply as a form of vertigo. Vertigo is "a state in which it seems that all objects are turning round; or that the individual himself is performing a movement of gyration." Dungliesson. "The sensation of moving, or the appearance of moving objects without any real existence of movement." J. Spence Ramskill, in Reynolds's System of Medicine. So others might be quoted; but in all the idea of circular motion is mentioned as a prominent characteristic. A person subject to vertigo might dread to cross a street alone, but why he should have a similar dread when sitting in a crowded theatre, is not so easily explained. However, there is no question of vertigo in these cases. Three patients, whom I have seen since writing my last article, expressly deny that there is any sensation of dizziness or any swimming of the head. One of these could not cross a public square, was obliged to turn back and could not walk on the sidewalk next the square, but had to cross the street to the opposite side. Another, when at a concert or theatre felt oppressed or stifled, not from the close air of the room—for the same sensation was felt in a crowd in the street—but a sense as of want of breath, and she thought she should faint if she gave way to the feeling; her heart beat violently. The third patient was not dizzy except when she had a severe headache. She, however, had the sensations called agoraphobia on crossing a street or a square to to such a degree that she would be obliged to come to a stop and wait a few minutes before proceeding. She expressly said she was not dizzy at such times, and did not think of being dizzy.

I have seen patients in whom the vertiginous motion seemed to be around the longitudinal axis of the body; another in

whom it was around an axis perpendicular to this axis, so that when upright, objects seemed to revolve over his head. Again, I have had a patient who complained of an undulatory sensation when walking, as though he were on board a ship. Another has complained that the ground seemed to rise to meet him as he stepped, which may be the same as the last, differently described. I can understand how any of these sensations may be spoken of as a form of vertigo; but when there is no sense as of motion, no swimming of the head, I do not see the propriety of using the word vertigo, or even the expression, "a form of vertigo."

Dr. Williams objects to the name of agoraphobia, and that, for consistency, appropriate classical terms ought to be given to dread arising under other circumstances, as ecclesiaphobia. Inasmuch as *agora* means not only a market-place, but also an assembly of people, the term agoraphobia would seem appropriate for the dread of crossing a square, or dread of being in a crowded room.

Dr. Williams has attempted to weaken the importance of the symptom we are considering, because it occurs in connection with other symptoms. If a person knows what vertigo is, he would be less likely to confound it and agoraphobia; because he has fits of an epileptic character, it does not follow that agoraphobia is epileptoid.

In each of the cases criticized, there were causes operating which might well produce the condition of irritable weakness or nervous erethism to which Dr. Cordes refers agoraphobia as a symptom, and it is not at all singular that other symptoms should be present referable to the same condition.

Dr. Williams does not describe the nature of the uneasiness to which he is subject under certain conditions accurately enough to render it certain whether he has ever experienced the sensation referred to as agoraphobia. In view of what he says, I can only suppose that he is not personally acquainted with it, and therefore has mistaken his sensations for it; it would also seem that he has not met persons suffering from this symptom or has not carefully questioned them in regard to their sensations. Otherwise, I do not see how he should confound it with vertigo.

However, Dr. Cordes touches upon all the points which I wish to mention.

Dr E. Cordes prefers the name Platzangst to Agoraphobia. He says that some years ago, while greatly exhausted, he was him-

self suddenly attacked with a feeling of very great mental fear while in a crowd of persons at the theatre, against which the strongest effort of the will was unable to contend successfully, and he was obliged to leave the theatre. He also subsequently had the sense of fear on crossing a wide place. Improvement followed on reëstablishment of the general health.

Platzfurcht he is firmly persuaded should be looked upon not as a clearly specific disease, but it represents only a precise species of certain psychical sensations of terror, of varying import, which are more or less similar, not differing in their quality, but only in their intensity, and all having the same cause; not that the notions and groups of ideas are always exactly the same—this would be psychologically impossible—but the train of ideas called forth is in the same circle of conceptions, united with nearly the same feeling of fear. The sense of terror in its lowest grade is shown only in the idea of fear lest some undefined evil should occur, the account of which differs according to the sensations of the patient, but is rather subacute. This lowest variety of fear increases partly intellectually, partly corporeally, while the one gives rise to ideas of terror, as also the other excites a sensation, not mental but bodily, until the whole mind is thrown into such anguish by this undefined something, this threatening terror, that strong reflex influence is exercised over the motor faculties. Excessive palpitation is added thereto; an indescribable præcordial anxiety, oppression of the chest, efforts for breath, sensations of heat, alternating with cold and shivering, variations of temperature are present. A multitude of abnormal sensations run through the body and naturally increase the anguish still more; these sensations are especially like syncope; sense of diminishing power, as well bodily as mental. Soon pains darting through the head, dimness or glimmering before the eyes, sounds in the ears, nausea, a feeling like an aura rising from the stomach, weakness in the limbs or in groups of muscles in other parts of the body, formication, sense of flushing, &c., are mingled confusedly together, and excite the most indefinite succession of ideas, which end and culminate in the sense of indescribable anguish.

In the lower degrees of this sense of agony the will can overcome it; as it becomes more severe, however, it overpowers the will and the body dominates the soul. In this condition every impression upon the nerves of sense excites powerful reflex conditions. He considers the platzangst

as only one variety of this sensation of psychical anguish, which arises nearly always in the same way.

The feelings and sensations which the patient experiences during or before crossing a large square are never analogous to vertigo; never is there a feeling as if the patient or surrounding objects turned round; never is there apparent metion, but always he feels a sense of powerlessness, as if he could not go forwards, as if chained to the ground, and from this arises the fear of inability to cross the place. This anxiety increases sometimes to such a pitch that genuine reflex paresis results, and there is momentary inability to perform coördinated motions of the legs. If the patient can control himself sufficiently to go slowly and retard his motions, instead of trying to overcome the paresis by rapid walking, he sees that he has not lost power over his limbs, that the anxiety was unnecessary, and he becomes quiet and can then cross the square.

Agoraphobia is caused by associations of ideas derived externally; it is not a disease by itself, but only a symptom, whose basis, in common with that of other similar symptoms, we must seek. At the foundation of these sensations of anxiety lies one common, or at least similar, corporeal cause. They occur in a certain pathological group, including what may be expressed by the name nervous irritability, crethism, irritable weakness. As yet this is a very unprecise term; by it may be understood an increased impressionability for irritations, as well of the peripheral sensitive nervous system as of the organs of sense, which are so reflected upon the central nervous system that not only the psychical but also the entire nervous system, the motor, vaso-motor and trophic may be thrown into extreme commotion, followed often, not always, by great exhaustion. The causes which call forth this changed centripetal and centrifugal nervous conduction, may vary; whether the anatomical basis varies equally is as yet unknown to us, and will remain unknown until we have more data. Yet each step which we take in the more correct grouping and classification of single symptoms belonging to nervous weakness marks an advance which brings us nearer a knowledge of the anatomical basis.

Cordes gives the histories of three patients as examples of the three groups:—1st, where the anxiety is felt in the presence of large numbers of people; 2d, when alone; 3d, agoraphobia proper.

He finds that all the 29 patients suffered

from a, so-called, irritable weakness; that they all, under certain conditions, had a sense of anxiety or terror; that the causes through which the nervous erethism arose may be referred to a few, chiefly three, divisions:—1st, mental over-exertion; 2d, dissolute life; 3d, chronic gastric disturbance.

The same symptoms will not invariably follow every cause of debility. There seems to be one symptom which forms the characteristic difference between exhaustion caused by dissipation, mental over-exertion and gastric disturbance, and the exhaustion arising from other causes. This symptom is *tremor*, from which all the patients under consideration suffered.

Tremor must be considered as an excess of muscular action which easily passes into a deficiency of muscular action. It may arise from over-irritation of peripheral nerve-endings, in the reflex centres or in deficient action of the will. In all the patients whose cases are included in the table, and whose affection depended upon the three causes above mentioned, the tremor depended upon defective impulse of the will. This tremor is not like that which is seen after typhus or after extreme bodily exertion. These patients can take long walks without being tired, can stand for hours without trembling, can work half the night and lie without sleep the other half, and the next morning show no sign of trembling. So soon, however, as certain groups of ideas seize their minds, a severe tremor appears, against which every resistance is powerless, which, with the invariably accompanying fear may even cause paresis.

It seems to be characteristic of this action of certain exhausting irritations that the control of the will over the motor centres is disturbed. It would seem also that in such cases there is a pathological change, as yet unknown, in that part of the brain which is concerned not only with locomotion, but also with general muscular sensibility, so modifying the mind that after the sensation of fright, a tremor may arise and, in the highest degree, a paresis of the muscles. This sensation of mental terror is never found with the tremor after typhus.

Agoraphobia is a variety of functional paralysis which, neither in its import nor in its grouping of symptoms, nor in its effects, is anything else than a certain degree of intensity of the mental terror before referred to.

One patient represented that seeing a large crowd on the ice he became suddenly dizzy. On more careful questioning, it

was found that there was no dizziness, no semblance of motion in surrounding objects or in himself; but on account of a succession of sensations resembling faintness, dimness and glimmering before his eyes, instability of the legs, &c., he was overpowered by the thought that it would be impossible to pass over the smooth ice and among so many persons.

The sense of terror here described differs essentially from the stomachal vertigo described by Trousseau. An important diagnostic mark is that this sense of terror arises from the same circumstances, in a wide place, in the midst of a crowd, as when alone; it may also be voluntarily excited, which is not the case in stomachal vertigo.

In all the cases the eyesight was intact; in none was there an epileptoid condition or true epilepsy. True paralysis or paralytic symptoms did not appear apart from the condition of terror. In most cases—all except four—the nutrition was good, the muscles being compact and firm, exertion did not cause weariness. Men were chiefly affected; one woman only had the disease, and she had also Basedow's disease; the patients were in the vigor of life, and from the better classes. It was not uncommon for the patients to fear lest they should become insane, or should die suddenly. All, however, recovered.

Progress in Medicine.

REPORT ON SURGERY.

By J. COLLINS WARREN, M.D., Boston.

(Concluded from page 434.)

Ovarian Tumors: their Pathology, Diagnosis and Treatment, especially by Ovariectomy. By E. RANDOLPH PRASLEE, M.D., LL.D.

In the chapter on the classification and pathological anatomy of ovarian tumors, we find the following varieties mentioned:

1. Solid ovarian tumors consisting of, 1, Enchondroma; 2, Osteoma; 3, Carcinoma; 4, Papilloma; 5, Fibroma of the Corpora Lutea or of the Stroma.

Carcinoma of the ovary is placed among the rare forms. The encephaloid form is said to be the most common, but it is considered by the author to be less so than scirrhous. Cancer is said usually to affect both ovaries. Spencer Wells has seen but three cases in his first four hundred cases of ovariectomy, and the author has seen but two undoubted and two strongly suspected

cases in over two hundred. In regard to colloid cancer, he says, "no amount or variety of consistency of colloid contents of an ovarian cyst demonstrates its malignant character, and the expression should be dropped."

II. Of cystic ovarian tumors there are three classes: 1, Hydrops Folliculorum; 2, Cystoma Ovarii; 3, Dermoid cysts.

The most frequent form is the cystoma, which is subdivided into Struma, Oligocysts and Polycysts. The term oligocystic is used instead of monocystic, as the occurrence of a tumor originally monocystic is extremely rare and incapable of demonstration, and in most cases is derived from the oligocystic form, which consists of a limited number of cysts. This form has an entirely different origin from the polycystic, and is far less likely to become adherent to parts and organs in contact with it. Struma ovarii is a very rare form. In oligocysts the abnormal development of the papillae may be mistaken for medullary cancer, particularly if the cyst bursts when we find the papillae projecting from the collapsed cyst, and increasing in length and size. The multilocular or polycystic cystoma seldom affects both ovaries. If the contents be removed by tapping, they are more speedily reproduced, and the mass grows more rapidly than in the case of the oligocyst. Dermoid cysts generally affect but a single ovary and are single cysts. They do not grow so rapidly nor attain generally to such dimensions as the cystomata previously described, being seldom larger than an adult's head. They almost always present a secreting surface within, in addition to the dermoid portion, so that their contents are always to a greater or less extent fluid. "Of all the forms of ovarian tumors the fibroma constitutes decidedly less than one per cent., and may be stated at one-half per cent.; the true monocyst constituted three per cent. in Dr. Keith's cases; the dermoid cyst may be estimated at one and one-half to two per cent.; the oligocyst at thirty-eight per cent., and the polycyst at fifty-seven per cent. Carcinoma is about as frequent as fibroma."

The duration of growth is about two years for polycysts, and two and a half or more for oligocysts. Adhesions are always more common, more extensive and more vascular in polycysts than in oligocysts.

In regard to their origin, the oligocyst commences as a dropsy of the ovisacs, and may practically be considered simply as a larger development of the hydrops folliculi,

and the polycyst as a colloid degeneration of the ovarian stroma. The dermoid cyst originates very early in embryonic life by a displacement of a minute portion of the outer layer of the blastodermic membrane, so that it enters into another part or organ. Congestion or inflammation of the ovary may be reckoned among the exciting causes of cystoma ovarii, and the non parturient condition among the predisposing causes.

Among tumors often mistaken for ovarian cysts, are mentioned cysts of the broad ligament, hydrosalpinx (dropsy of the Fallopian tube), and uterine fibro-cystoma.

In regard to the medical treatment of ovarian tumors, the author remarks: Since the cysts increase more rapidly after the patient's health becomes decidedly impaired, much may be done by appropriate medication in the way of sustaining the general health during the growth of the cyst.

Paracentesis abdominis may be employed as an aid to diagnosis, as palliative treatment, or with a curative intention when followed by other treatment. Tapping an ovarian monocyst is not a dangerous operation, but tapping a polycyst is very dangerous, and should never be performed except for diagnostic purposes, the dangers being liability to hemorrhage and inflammation, and peritonitis resulting from the extremely irritating character of the fluid of the polycyst. In regard to prognosis, the polycyst may be said to be as fatal as any malignant disease. The dermoid and oligocyst require a somewhat longer time to exhaust the vital force.

The surgical treatment may be either palliative or curative; the former consists of tapping per parietes abdominales or per vaginam. Among the various forms of surgical treatment, tapping followed by injections of iodine has been employed by some surgeons. It should be employed only in cases of monocyst without complications of any kind as to its walls, and therefore in its first or second stages, and then only in exceptional cases. Tapping, followed by maintenance of a permanent opening into the cyst, particularly per vaginam, as recommended by Dr. Noeggerath, is of the highest value in those cases of ovarian cyst, to which, on account especially of adhesions, ovariectomy is not applicable. Dermoid cysts may be also treated in this way.

Ovariectomy is the only curative procedure to be recommended for all ovarian cysts which have passed beyond the commencement of the third stage, and for polycysts at any stage if found to be undermining

the general health. It may also be employed for all solid tumors and all dermoid cysts. Ovariectomy, in well selected cases, is not comparatively a dangerous operation, ninety per cent. recovering in the hands of experienced operators. According to Billroth, its danger is about the same as that of amputation of an arm, excision of the shoulder, lithotomy in the young and similar operations.

The operation should not be performed until the general health has become somewhat impaired. According to Spencer Wells "patients in full health do not do as well as those accustomed to an invalid life." Many other weighty reasons are given by the author for deferring the operation until this time. It is also desirable to wait, *ceteris paribus*, till the abdominal walls have been decidedly thinned by the development of the tumor; a thickness of more than one inch being very undesirable. The operation has never succeeded in large hospitals so well as in private practice, but in small hospitals the success is about the same as in private practice. The account of the different steps of the operation is remarkable for its clearness and the thoroughness of its detail. We cannot attempt to enumerate in a report like this, many points which we should be glad to call attention to. The length of the incision has varied from time to time greatly. The author lays down three inches as the length to begin with, which may be prolonged if necessary. The opening into the peritoneum should at first not exceed one and one-half inches. The author describes, in addition to Mr. Wells's trocar, a very ingenious instrument devised by Dr. Mears, of Philadelphia, but prefers himself to use a simple trocar from three to five lines in diameter. If the adhesions are extensive and intimate, the fibrous layer of the cyst should be separated from the peritoneal covering, which should be left in contact with the viscus, to which it is attached. Cases in which the lower portion of the cyst occupies the whole pelvis, and is everywhere adherent to the contiguous organs, have generally been abandoned. Even these will be found manageable by following Dr. Miner's method of enucleation. As there will almost certainly be some oozing after the incision is closed, in these cases, it is judicious to leave a bougie passing up the vagina and through the roof of the latter into the peritoneal cavity, to afford proper drainage. No less than twenty odd methods of treating the pedicle are enumerated and described, and the comparative merits of the ligature and clamp

VOL. X.—No. 26a

are discussed at length and with great fairness. Dr. Peaslee uses a double ligature; if, however, the pedicle is over six inches wide, he divides it into three portions. The pedicle should be allowed to fall into its normal condition, the ligature being cut close to the knot or otherwise. Metallic or silk sutures may be applied, and it is important that the peritoneum and the recti muscles should be included within the suture. In concluding his very admirable account of this important operation, he justly lays great stress upon the fact that success does not depend upon the performance of any single step of the operation, but on the bestowal of the greatest care upon all its details. Equal care and skill are required, in complicated cases, in the after treatment, which it is very desirable should be directly supervised by the operator himself. We may add in conclusion that great thoroughness is shown in Dr. Peaslee's treatment of all the details of this very admirable work, which from the very attractive and readable form in which it appears, is likely to do much good in the way of spreading a more general knowledge of the importance and advantages of this operation than exists at present.

General and Differential Diagnosis of Ovarian Tumors, with special reference to the operation of Ovariectomy. By WASHINGTON L. ATLES, M.D.

This book is divided into two sections, Section I, consisting of one chapter only, and being devoted to the general diagnosis of ovarian tumors. We find here many points of interest, but have space for the mention of a few only. "One of the most important means of diagnosis is tapping. It generally affords us undoubted information of the presence or absence of ovarian disease, aids us in detecting adhesions and in deciding upon the true character of the tumor." Ovariectomy ought never to be performed by the inexperienced surgeon without previously resorting to tapping as a means of diagnosis. A large trocar should be employed, for even with the largest sized canula it is sometimes difficult or impossible to draw away the fluid in consequence of its viscid character. The point to be selected for tapping is the linea alba, at a point from two to four inches below the umbilicus. A rare complication may be met with when the tumor has formed adhesions with the bladder, and dragged it upwards towards the umbilicus. The examination of the bladder with a sound would render the accident of puncturing this organ in tapping impossible. It is well to incise the

cutis with a sharp bistoury and puncture through the wound. This diminishes the pain and enables the wound to heal readily.

Section II. contains twenty-one chapters on the differential diagnosis, each chapter being devoted to a particular condition liable to be mistaken for ovarian tumors. Chapter twenty-two is on adhesions. In regard to these he says: "I think the large mass of the profession is at a fault in magnifying the importance of adhesions, and in dreading to encounter them . . . Indeed, it is surprising to see how rapidly a patient will sometimes recover after a most desperate operation, involving to a great extent the most vital abdominal organs." Adhesions are not likely to exist if the tumor has originated without pain, if, when small or reduced in size by tapping it is found to be movable, if deep inspirations are accompanied by downward motions of the tumor, if the functions are all properly performed, or if a vaginal examination shows the pelvis to be free from an unyielding tumor. Ovariectomy in such a case offers better results than any other established capital operation in surgery.

Adhesions may be parietal, omental or visceral. Parietal adhesions may be produced by inflammation, or by pressure from the enormous size of a growth or from tight bandaging. Visceral adhesions are the rarest and most fatal complications of ovarian tumors. The intestinal canal is the organ most frequently implicated. The presence of visceral adhesions should not positively forbid an operation.

Chapter twenty-three is a valuable contribution to this work, by Dr. J. Ewing Mears, on the pathology of cystic tumors of the ovary. The most frequent encysted tumors of the ovary, among those examined, were the multilocular or proliferous variety; the next in number were those known as the multiple; and the most rare were the simple or unilocular cysts. Under the name of multiple cyst is described that form of cyst which is simple in character and differs from the multilocular variety in the respect that there is a development of more than one cyst in the substance of the ovary. The multilocular differs from the simple and multiple cysts in that it embraces a class of cysts composed of one large or parent sac, with numerous smaller cysts developed within or upon its walls. Within the smaller or secondary cysts there may be developed a third order. Ovarian cysts may originate in simple dilatation of a Graafian follicle from cells or nuclei, or in the areolar spaces, the first being the

frequent form of origin. "In the interruptions to the proper completion of ovulation, whether due to hyperplasia of the tunics of the ovary or to the non-development of the ovisacs, we think is found, to a great extent, the cause of the cystic degenerations of the ovary."

In the examination of ovarian fluids by Dr. Drysdale, it is found that the chemical constituents of these fluids are almost the same as those found in other dropsical fluids, but differ from them, however, in the excessive quantity of solid matter which they contain. The microscopic examination of ovarian fluids shows that, no matter what other cells may be present or absent, the cell which is almost invariably found in these fluids is the granular cell.

Ovariectomy by Enucleation, without Clamp, Ligature or Cautery. By J. F. Miner, M.D. (*American Journal of the Medical Sciences*, October, 1872). Dr. Miner first operated in this way in 1869. The case was one of extensive adhesions, from which the cyst was separated by enucleation, by which process the pedicle, although large and extending over a wide surface, was separated from its entire attachment to the tumor. The bleeding from the terminal branches of the vessels of the pedicle was not greater than that from the attachment elsewhere, and all hæmorrhage soon ceased. The patient died on the twenty-first day after the operation, but apparently not from hæmorrhage. The author and other surgeons have since practised this method successfully. He is of the opinion that all ovarian tumors, capable of removal, can be and should be removed by enucleation.

Normal Ovariectomy. By Robert Battey, M.D. (*Atlanta Medical and Surgical Journal*, September, 1872). Dr. Battey defines this to be an operation for the removal of the normal human ovaries, with a view to establish at once the "change of life," for the effectual remedy of certain otherwise incurable maladies. The case reported was one of amenorrhœa, treated for several years unsuccessfully, the patient's sufferings being so great that it was decided to remove the ovaries, which was effected through an incision in the linea alba. The base of the attachment of the ovaries was tied on each side by a double ligature, the ends of which were cut short. On the thirty-first day the wound had nearly healed. Comment on this truly heroic treatment is hardly necessary.

Antiseptic Treatment. Dr. Paul Güerbock (*Archiv für Klinischer Chirurgie*, xiii, 2, p. 272, 1872) gives a very elaborate

account of the advantages and disadvantages of Lister's dressings, as observed in the Bethanien Hospital, at Berlin. Lister's complaint that his method is not always carried out is answered by the statement that the method has been frequently modified very materially. The Germans have not thought it proper to apply carbolic acid directly to the wound, owing to its cauterizing power, and use it only in the later stages of treatment and in a mild form, and even then the caustic action is not entirely avoided. Lister's later modifications have obviated this difficulty somewhat. The acid does not act deeply in the tissues when employed as a caustic to gangrenous and diphtheritic wounds, and moreover the appearance of the tissues after its application resembles strongly these diseases. It is not therefore to be relied upon for this purpose. Dr. Güterbock finds that the acid retards the healing process. There is but a slight tendency to a reactive inflammation as well as to cicatrization. One of the chief objections to the method is the rarity of healing by first intention when it is employed, one part to thirty being sufficient to prevent it. Prolonged application gives rise to excoriations and eczema in the neighborhood of the wound, remaining long after the wound itself has healed. These complications occurred, however, in comparatively few of his cases. Lister's plan was not successful in the majority of cases, and afforded no protection to hospital diseases. As proof of this statement the author describes thirteen cases of compound fracture, in three of which the wounds were so small that they might easily have healed with the ordinary dressing; the other ten showed all the disadvantages of compound over simple fractures. They were not exempt either from erysipelas or hospital gangrene. In the opening of cold abscesses no success was obtained in antiseptic after-treatment. He has had the best success in wounds and acute suppurations of joints and serous cavities. Injuries to the sheaths of tendons were also successfully treated in this way, but in phlegmonous inflammations and acute abscesses, he had no success. The general sanitary condition of the hospital was not improved by this treatment, as is asserted to be the case by Lister. In reply to the statement of Lister that this method shows a reduction in the percentage of deaths after amputation and resection, the author says that the results in the Bethanien Hospital at the time this treatment was not in vogue were quite as good as those given

by Lister. This method has many disadvantages which are constant, while success attends this treatment only occasionally. Dr. Güterbock's treatment seems to have been faithfully carried out, and his article is therefore a valuable contribution to the literature of this subject. This is more than we can say of the very imperfect trials on which the majority of surgeons have based their opinions one way or the other. It is well known there are good surgeons who think that Lister's treatment has stood the test of trial.

James Cummings, in a prize essay on the antiseptic treatment, given by the university of Edinburgh (*Edin. Med. Jour.*, xvii. p. 985 [No. cciii.] May, 1872) reports favorably on Lister's method. He states that Lister during the first nine months of his service in the wards of the Edinburgh Infirmary had not a single case of pyæmia. Cummings also during the last two years and a half had not seen a case of pyæmia or hospital gangrene in his wards, although these diseases previously had occurred quite frequently.

Dr. A. Burger (*Arch. f. Klin. Chir.* xiii. 3, p. 432, 1872) publishes an article on the action of carbolic dressings on wounds already in the stage of suppuration. The cases occurred in a military hospital during the Franco-German war. In the severer cases the antiseptic treatment was employed. In compound fractures, when the wounds were in bad condition and there was considerable fever, this mode of dressing was attended with the most satisfactory results. Although he is far from believing that this was solely due to the method employed, yet it is quite evident that a portion of the patients, at least, owed the preservation of their limbs and their lives to this method, which was also very effective in preventing the appearance of pyæmia, erysipelas, and hospital gangrene. (*Schmidt's Jahrbücher*, 1872, No. 5.)

M. Ollier's *Occlusive Dressing* (*Medical News and Library*, October, 1872).—In the last two numbers of the *Lyon Medical*, M. Poncet brings forward some new illustrations of the great advantage attending the employment of M. Alphonse Guérin's mode of dressing wounds with cotton, and associated, as recommended by M. Ollier (*Medical Times and Gazette*, May 11, p. 547), with the silicate bandage, so as to constitute what the latter surgeon terms *occlusion inamovible*. The object of these papers is, however, not to set forth the general advantages of this plan, which have now been made pretty widely known, but to show its

great utility in warding off those hospital complications which have so often excited terrible effects—pyæmia, erysipelas, and hospital gangrene. During the last semester more than one hundred of the *bandages ouaté-silicatés* have been applied in M. Ollier's ward (containing one hundred patients) to every wounded surface, and not one of these patients has succumbed to pyæmia or been attacked by erysipelas. The bandage in these cases has been kept on for a week or a fortnight, and sometimes three or more weeks; all accidents by such retention being guarded against by paying attention to the pulse, temperature and feelings of the patients. The bandage has had to be removed wholly or in part in a few cases, on account of the imperfect way in which it had been applied. In all cases, wherever possible, such removal has not been performed in the ward where the other patients were; the wound being also kept exposed for the shortest possible time; and the quite new, fine cotton taken only from the parcel as wanted. The portion of this brought in immediate contact with the wound has usually been impregnated with carbolic acid or alcohol. In this mode of dressing the minutest details must be observed, and the great object of exclusion of air can only be attained by the superposition of several thick layers of cotton, which must reach very far beyond the surface of the wound. Thus, after an amputation of the leg, it does not suffice to cover the stump with the silicated bandage, but this must also comprise the thigh and the trunk. Without such precautions it becomes a bad mode of dressing, retaining pus which has undergone change from action of the air in contact with the wound. Before the bandage is applied, as many arteries as possible should be secured, and for this purpose the wound should be left exposed for fifteen or twenty minutes.

It is a means especially adapted for hospital practice, and is not required in cases treated in localities where the air is not likely to be contaminated. The cases M. Poncet relates were also treated in the winter; but in summer the dressing may have to be renewed every five or six, instead of every fifteen or twenty days.

Torsion (British and Foreign Medical-Chirurgical Review, July, 1872).—The application of torsion of the larger arteries does not gain favor with the profession, and is probably due to the natural fears and dread of insecurity of the plan. Nunneley, in his address in 1869, on "Surgery," says: "I must say I could not twist a large ar-

tery and lie comfortably in bed the next night, lest, while I slept, the elastic artery should untwist itself and my patient bleed until he slept never to wake again." This dread is proved most incontrovertibly to be a truly false alarm. At Guy's Hospital, a ligature is seldom or never used; torsion is practised with unparalleled success. We have applied torsion to the subclavian artery in amputation of the shoulder-joint, and without failure; but we should not be disposed to attempt it again, as the artery is too loose and the twist is not confined to the lower part of the artery, the artery requiring to be drawn out and held at some distance in order to apply the torsion properly.

Lister prefers the antiseptic catgut ligature for securing vessels, and in his address on surgery (*British Medical Journal*, Aug. 26, 1871) he says: "Although I have used nothing but this ligature for securing vessels in wounds for more than ten years, excepting torsion, which I comparatively rarely resort to, and though in certain classes of cases putrefaction cannot be avoided, in no instance have I seen the catgut knot come away, nor have I ever known secondary hæmorrhage or abscess by its use."

The antiseptic catgut ligature for arteries, introduced by Prof. Lister, is one of the most important additions to the progress of surgery; its use is still in its infancy, and great results are anticipated in its application to the larger trunks, where the silk ligature has failed. He thus sums up its value: "It appears then that by applying a ligature of animal tissue antiseptically upon an artery, whether tightly or gently, we virtually surround it with a ring of living tissue and strengthen the vessel when we obstruct it. The surgeon, therefore, may now tie an arterial trunk in its continuity close to a large branch, secure alike against hæmorrhage and deep-seated suppuration; provided always that he has so studied the principles of the antiseptic system, and so carefully considered the details of the mode of dressing best adapted to the particular case in hand, that he can feel certain of avoiding putrefaction in the wound. For my own part, I should now without hesitation undertake the ligature of the innominate, believing that it would prove a very safe procedure.

"The catgut, as tied in the ordinary reef-knot, with the ends cut short, seems to me to be a perfect hemostatic. It has all the simplicity and universal applicability of the ligature, with, at the same time, the

virtual absence of any foreign body from the wound."

Strangulated Hernia. Since the occurrence of Dumarquay's case of strangulated hernia treated by puncture and aspiration (*Med. Times and Gazette*, June 1st), a discussion took place on this subject at the Société de Chirurgie, July 31st, 1872 (*Gazette Hebdomadaire*, No. 34, p. 555), at which a number of similar cases were reported. M. Henry reported several unsuccessful cases and asked for the indications and contra-indications for this operation. An irreducible hernia of four days' duration was punctured on two separate occasions without in any degree diminishing its volume.

M. Verneuil reported a case of scrotal hernia strangulated for sixteen hours. The hernia, habitually retained, came down very suddenly; as there was fluctuation, puncture and aspiration was tried and four hundred grammes of a rose-colored liquid were withdrawn. A hydrocele of the sac was found to exist. An attempt was then made at reduction under chloroform, without success. A second puncture did not diminish the size of the tumor, although a little gas and blood were withdrawn. A third puncture drew some blood. An incision was then made, and the intestine, being exposed, was found slightly livid in color, and perforated in three places, from which a little blood exuded. The intestine was reduced and the patient recovered. The puncture should not be resorted to in old strangulations, for perforation of a diseased intestine might entail disastrous results. The puncture had done no injury, but the intestine had been punctured three times to no purpose.

M. Panas had made two attempts at aspiration in hernia. In a woman with left crural hernia, a puncture with aspiration obtained fluid from the sac merely, about thirty grammes; a second puncture gave no result. The hernia was finally reduced by taxis. The strangulation had existed forty-eight hours. The patient died the following day. There was no autopsy, but it was supposed that a perforation of the intestine was followed by peritonitis. In a second case, puncture was first tried, and then kelotomy was performed and the hernia reduced with a fatal result. He concludes that puncture and aspiration are only useful at the beginning of the strangulation.

Mr. Bryant appears to be the first to have employed this method. A case is reported operated upon by him in 1871 (*Med.*

Times and Gazette, August 3, 1872). Flatus but no fecal matter followed puncture by a grooved needle. He thinks that puncture of the intestine may be freely resorted to in some cases with every prospect of success.

Dr. Léon Labbé reports a case of aspirating puncture to the *Lancet* (July 20, 1872). A man, aged 70, after coughing, perceived a tumor about the size of the fist in the right inguinal region. Two efforts at taxis were made without success. The strangulation being of only eighteen hours' duration, it was decided to puncture with a No. 2 needle. About two drachms and a half of a yellowish liquid immediately escaped, together with a quantity of gas. The tumor collapsed, and gentle pressure caused complete reduction of the hernia. No bad symptom of consequence followed, and the patient recovered (*American Journal Medical Sciences*, Oct. 1872, p. 551).

M. F. Ferrier read a case before the Société de Chirurgie, Oct. 30, 1872, of crural hernia in a patient 66 years of age; puncture with aspiration obtained a few ounces of liquid and a quantity of gas, and was followed by a diminution in size of the tumor, which, however, soon enlarged. Two more punctures were also without result. Kelotomy was finally performed successfully twenty-four hours after the beginning of the strangulation. The three punctures could not be found. The punctures with aspiration had not been successful, but also had not complicated the case.

A new Case of Extirpation of the Kidney, with remarks. By George A. Peters, M.D. (*New York Medical Journal*, Nov. 1872). The patient, a lawyer, aged 36, had suffered for two years, and at time of entering hospital complained of pain in right lumbar region shooting down into pelvis. A tumor occupied the region of the right kidney, and large quantities of pus were discharged with the urine. The tumor was punctured with Dieulafoy's aspirator, No. 2, and 3 ounces of clear pus withdrawn. Small masses of granular matter were found in the eyes of the instrument, supposed to be fragments of a calculus. The diagnosis was calculous pyelitis, and nephrotomy was performed nine days later. An incision was made six and three-quarter inches in length, extending from the lower border of the twelfth rib to the crest of the ilium, parallel to and three inches from the vertebral spines. No calculus was found. The kidney was much enlarged and filled with cavities containing cheesy material. The patient died, three days after the operation,

of exhaustion, without any special symptoms of uræmic poisoning. In the *Deutsche Klinik*, 1870, a case of nephrotomy is reported by Simon. During an ovariotomy the ureter was accidentally cut, leaving a urinary fistula above the symphysis pubis communicating with the left kidney. Efforts having been made to establish a connection between the ureter and the bladder without success, the kidney was removed. The patient was able to sit up at the end of six weeks, but the ligatures did not come away until after the end of six months. Two other cases have been reported, both of which terminated fatally. (*Wurtemberg Correspondenzblatt*, No. 61.) (*British Medical Journal*, May 18, 1872.)

Puncture of the Bladder by Dieulafoy's Aspiration, with Description of the Instrument. James L. Little, M.D. (*New York Medical Journal*, Nov. 1872.) The case was one of retention from enlarged prostate. A nick in the integument was made about an inch and a half above the pubes, and capillary trocar No. 2 was passed through the tissue into the bladder, and 800 grammes of bloody urine removed. The same evening a second puncture was made, and during the next four days twelve punctures were made; after this it was found possible to pass a catheter. Mr. Watelet states in a pamphlet ("De la Ponction de la Vessie à l'aide du Trocar et de l'Aspiration pneumatique," Paris, 1871):

1. The capillary puncture is an operation entirely free from danger.

2. In all cases it should be substituted for the ordinary hypogastric puncture.

3. The bladder may be punctured three or four times a day, and replace catheterism where that operation is impossible.

Traumatic Rupture of the Urethra; Puncture of the Bladder in the Hypogastric Region; External Urethrotomy; Cure.—De Bousseou. (*Union Médicale*, 1872. No. 81.) (*Centralblatt*, No. 36.) A man 52 years old slipped and ruptured the urethra; a few weeks later the stricture was so tight that the finest bougie could not be introduced, and there was almost complete retention of urine. External urethrotomy was attempted, but in the thickened cicatricial tissue it was not possible to find the urethra, and the bladder was accordingly punctured above the symphysis, the wound in the perineum being kept open. On the fourth day after the operation a sound with a strong curve was passed through the tube of the trocar, into the bladder, and guiding it with the finger in the rectum, it was passed through the neck of the bladder into

the urethra up to the lower end of the stricture. The end of the sound was now cut down upon from the perineal wound, and the urethra opened. The cure was rapid and complete. Four similar cases are reported performed by Chopart, Baseilhac, Voillemier and Wilms.

Experiments in Grafting Portions of Mucous Membrane from the Tongue and Cheek of the Rabbit and Ox, into the Human Subject.—Houzé de l'Aulnoit (*Gazette Hebdomadaire*, 11 Oct., 1872). One of the principal disadvantages of epidermic grafting is the pain caused by the removal of portions of skin for this purpose, being sufficient in many cases to prevent the patient from submitting to the operation, or necessitating the removal of portions of skin from the surgeon himself.

The grafts employed, 5 millimetres by 2 and 3 centimetres, were secured to the wound by bandages of muslin covered with collodion in their internal surface or at their extremities, or with cotton wool lightly held down with diachylon plaster. In certain cases they are retained by gummed taffeta or by thin plates of lead, always keeping up a gentle pressure. The author thinks it possible even to retain the graft by a very delicate suture. The conclusions he arrives at are:

1. Mucous grafts taken from the tongue or cheek of the rabbit, like human epidermic grafts, can be grafted upon man.

2. They can be applied to fresh or granulating wounds, but never during suppuration.

3. New researches are necessary to determine the best method of immobilisation, and the time when the fluid dressing should be removed, which is placed by the author at the second or third day.

4. At the moment that vascular connection is established, the epidermis is detached, the cutis vera becomes inflamed and softened, and loses its physiological properties, and becomes a true pathological tissue, having some resemblance to the cicatricial tissue, without its contractility.

6. Adhesion was obtained but five times out of fourteen, four cases being doubtful.

7. Two attempts with the tongue of the ox were negative, caused by the condition of the wound or the dressing.

M. Ollier, of Lyons, considers that the connective tissue, and not the epidermis, is the active agent in the graft, and objects to sowing a number of small epidermic grafts. He cuts them from 6 to 8 centimetres in length and they succeed very well; but it is inconvenient to procure such large

grafts. He freezes the skin before cutting it away and finds that it still answers well, notwithstanding this assault upon its vitality. This is a veritable autoplasty, and the healed surface has a more persistent vitality than ordinary cicatrices. (*Brit. Med. Jour.*, Apr. 27, 1872.) (*Med. News and Library*, Oct. 1872.)*

Reports of Medical Societies.

SELECTIONS FROM THE RECORDS OF THE OBSTETRICAL SOCIETY OF BOSTON.

W. L. RICHARDSON, M.D., SECRETARY.

APRIL 13th, 1872.—The President, Dr. Read, in the chair.

A case of Recovery from supposed Rupture of an Abdominal Tumor, followed by partial Peritonitis. Dr. Borland read the case.

The patient, a young married woman, 24 years of age, entered the City Hospital, August 22, 1871. She stated that she had given birth to two children, and afterwards had one miscarriage in August, 1869, when three months pregnant. She was at that time ill about one week. The catamenia reappeared the following month and continued regular till May, 1871, when, during an interval, she was taken with cramps in the abdomen, and thought she felt something like a "lump." This, with occasionally recurring cramps, continued for about two weeks, when all these symptoms disappeared after free catharsis. After May the catamenia appeared every two weeks, and were profuse, prolonged, and occasionally painful. She was taken with cramps again two days before entering the Hospital, and the day before her entrance for the first time felt a decided tumor in the right side of the abdomen.

At the time of her entrance (August 22) she was unable to lie on her left side; the skin was hot and dry. She complained of chilly sensations and much frontal headache; tongue covered with a white coat. No appetite, but great thirst. No defecation for four days previous to discovery of the tumor. Breathing chiefly thoracic, deep inspiration causing abdominal pain; micturition slow, at times a little painful but unaccompanied by any smarting. The catamenia had reappeared four days before

entrance and were quite profuse. Pulse 120. Respiration 44. Thermometer 100½°. To the right of the umbilicus a tumor about the size of a child's head was evident on inspection. It was tender on light, but not on deep pressure, to which it gave a doughy feel, and seemed to yield somewhat. It was movable from side to side. *Per vaginam* the uterus and *cul-de-sacs* were free. There was no tenderness whatever.

The treatment was at first directed to relieving the intestines, and the bowels were freely evacuated in the course of thirty-six hours. She felt quite ill, with occasional attacks of cramps, and the temperature gradually rose till the morning of the 25th, when it was 102½°. From that time it gradually fell to the normal point.

August 31.—On deep handling, the tumor was felt to be about the size of a child's head and evidently did not extend into the pelvis. The uterus was movable, not attached to the tumor; the *cul-de-sacs* were free, and no local tenderness could be discovered. The sound entered 2½ inches, and its withdrawal was followed by a drop or two of blood.

Sept. 6th.—Dr. Sinclair, who examined her, reported that the uterus was not connected with the tumor, the former moving freely without motion of the latter. "Punctured with injection syringe, and bloody serum, containing pus corpuscles, was withdrawn—probably an old hæmatocele."

Sept. 10th. Patient was tapped with a small trocar and some 3iv of a dark, sticky, serous fluid was withdrawn. This was of about the same consistency as soft soap, and appeared to contain, according to a microscopical examination made the following day, a considerable number of renal casts. The patient thinks that at each attack of this sickness she has passed bloody urine.

Sept. 20th.—Patient thinks tumor is again enlarging. It can be plainly felt and moved from side to side, though apparently attached to the right side. The uterus is flexed ante-laterally to the right, but movable. When the tumor is pressed firmly down towards the right iliac fossa, a fullness can be felt in the right *cul-de-sac*.

Sept. 28th.—The tumor can scarcely be felt by external manipulation, but patient states that she is growing larger, having to loosen her dresses.

Oct. 2d.—Tumor felt crowded down into the pelvis, from which it can easily be moved; as on the 20th. When the tumor is pressed down into the pelvis, the uterus

* Writers of papers on Surgery will contribute much assistance in the preparation of the semi-annual reports in this department if they will forward copies of their papers, addressed to this JOURNAL.—EDS.

is pressed down on to the floor of the pelvis, lying in about the normal axis, or a little ante-flexed. When the tumor is pressed up under the ribs of the right side, the uterus is lifted and drawn a little to the left of the median line, without materially changing the position of the uterus. Uterus quite movable, sound entering three inches. Concavity forward.

Oct. 14th.—Is up and dressed. Tumor quite perceptible to touch, but apparently no larger.

Oct. 18th.—Catamenia ceased after continuing about a week. Discharged relieved, to take position as assistant nurse.

Jan. 16, 1872.—Patient entered Hospital again for treatment. Reports that about a month after entering on her duties as nurse the catamenia came on with some pain, and again in another month. Since that time they continued up to the present time with only one or two intervals of a few days each, the flow being rather profuse but with no clots. She has had occasional pains deep in the left side. This pain is especially severe after micturition, for which reason, patient has always tried to hold her water as long as possible. Tumor is now easily movable into right hypochondrium. She knows it has increased in size, as she has had to loosen her clothing. She had derived some relief from a bandage, which however she left off as it incommoded her.

Complaints of having felt miserably the past week, and last night the flow was "quite profuse." Appetite failing for the past week. Tongue slightly coated. Bowels, formerly inclined to be constipated, have been regular for some time past. Slight headache for a day or two. Pulse 90. Has been taking and is ordered to continue

R Fld. Ext. Ergot. β . ζ ss. *ter die*.

R Acid. Gallic. grs. viii. *ter die*.

Jan. 18th.—More pain at intervals. Flowing still, though the amount is diminishing. Feels weak, as she thinks, from loss of blood.

Jan. 19th.—Skin rather warm. Tongue slightly coated. Pulse 100. Cannot lie with legs extended. Abdominal pain quite severe, occurring at intervals. Entire loss of appetite.

Jan. 20th.—Patient lies on back most of the time. Can extend legs without difficulty. Pains come on at intervals, between which she is comparatively comfortable. Vomited several times yesterday. Flowing has about ceased. Pulse 120, strong. Omit medicine. Morphine *pro re nata*. Turpentine stupe.

Jan. 21st.—Face less expressive of pain.

Lies on right side with knees drawn up, but can extend them without pain. Pulse 104. Respiration 52, entirely thoracic. Temperature $102\frac{1}{2}^{\circ}$. Some vomiting. Tenderness confined to right side.

Jan. 22d.—Pulse 104. Respiration 36. Temperature 102° . Easier. Free from pain when quiet.

Jan. 23d.—Easier. Pulse 108. Respiration 48.

Jan. 28th. Tenderness having disappeared, an examination was made and the tumor was found to be much diminished in size and ill-defined. It is still somewhat elastic and elevates the abdominal walls a very little. Patient has had no discharge from vagina or rectum to account for this change.

February 7th.—Steady improvement having continued till date, she was discharged at her own request. At the time of her discharge the tumor was felt to be an elongated, hard mass, lying parallel with and to the right side of the vertebral column. The uterus and pelvic contents were fixed, the womb being glued down and immovable. This condition is exactly opposite to that of her commencing sickness, when the uterus was perfectly movable and a round elastic tumor could be moved about in the abdomen by external manipulation.

Dr. Abbot questioned whether this was not a case of movable kidney, with some inflammatory complication. The fact of casts having been found in the fluid which followed the tapping, the elongated shape of the tumor, its final location near the spine, its great mobility and its freedom from any attachment to the uterine appendages, all agreed exactly with the conditions in several cases of movable kidney which he had seen, and seemed to point to this diagnosis.

Case of Occipito-pubic Presentation. Version. Child dead.

Dr. Wellington reported the following case.

The patient had been confined seven times before. She had been suffering from what were reported to be labor pains for nearly a fortnight when Dr. Wellington first saw her. The uterus was very high up, the os being considerably dilated. The membranes were unruptured. At the time of his second visit a few hours later, the pains had increased in severity, and the membranes were protruding. The head presented, but in which position could not be made out. Dr. Wellington ruptured the membranes; but though the pains be-

came very severe the head did not advance. On making a more careful examination, the anterior fontanelle was found directly behind the symphysis pubis. The sagittal suture corresponded exactly with the line of the antero-posterior diameter. The patient was etherized and efforts were made to turn the head. This could easily be done; but it was found impossible to turn the child's body with it or to keep the head in position after turning it; podalic version was therefore performed. Some difficulty was experienced in extracting the head, on account of a slight projection of the sacral prominence. The child was born dead, owing probably to prolonged pressure on the cord.

Dr. Wellington said he had never seen but one other case of this presentation. In this the head righted itself and labor terminated naturally. In the case he had just reported the patient suffered from very severe afterpains, accompanied by considerable hemorrhage. After the removal, however, of a clot from the uterus, both the pains and the flowing ceased. The patient made a slow recovery.

RHODE ISLAND MEDICAL SOCIETY.

THE quarterly meeting of the Rhode Island Medical Society was held in Providence on the 18th instant.

Dr. F. H. Peckham, Sr., for the committee appointed to consider the resolutions sent to this Society by the Committee on Education of the American Medical Association in regard to elevating the standard of medical education by the united action of all the State Medical Societies of the country, said the committee deemed it unnecessary to report except on two propositions.

First—As to the appointment of a Board to examine those who propose to practise medicine. The committee were of the opinion that our present organization, with a Board of Censors, answers as well as the one proposed in securing a high standard in our members.

Second—As to a Board to examine students of medicine in their preliminary education. The committee think the object proposed a very important one, and believe this Society will cooperate in any wise plan to raise the standard of education in our pupils. The details for any specific plans for this purpose the committee referred to the Society.

Dr. W. O. Brown read extracts from Hal-

lier's Parasitological Investigations upon the Vegetable Organisms found in smallpox, cholera, &c.

The reading was in reference to the fermentation theory of disease, as proved by the various forms of microscopic fungus developed in the blood and excretions of the body.

Dr. Snow stated that the theories of the German doctors had been disproved in some points by Dr. Billings, of Washington.

Dr. George Capron read a paper on the "Abuse of Cathartics." He thought a great improvement had taken place in the use of cathartics since he commenced practice.

Dr. A. R. Becker, appointed to read a paper at this meeting, not being prepared, made a verbal statement of his experience in the treatment of "Dysmenorrhœa," and his method of practice in several cases successfully treated. The statement of Dr. B. awakened considerable interest, and discussion on the subject by Drs. Garvin, Perry, Clapp and others.

Dr. E. M. Snow, Superintendent of Health of Providence, was interrogated by a number of the members of the Society in relation to various phases and peculiarities of the smallpox.

Dr. Clapp gave an account of the origin of three cases in Pawtucket, all originating from one man who is supposed to have brought the disease from Boston. Dr. C. referred to the praiseworthy promptness of the Board of Health in Pawtucket in reference to providing accommodations for smallpox patients. The town authorities gave an order to a building firm in that place one morning, and before dark of the same day they had a comfortable building completed and ready for occupancy.

The following named persons, having presented written applications for admission as members of the Society, were approved by the Censors:—

Phanuel E. Bishop, M.D., of Pawtucket; George B. Haines, M.D., of Valley Falls; John W. Mitchell, M.D., of Providence; Wallace W. Potter, M.D., of Providence; James E. Tobey, M.D., of Central Falls; Miss Anita E. Tyng, of Providence.

The above-named gentlemen were all elected by ballot unanimously, and during the balloting further remarks were made upon the subject of smallpox by Drs. Perry and Whitney.

After a spirited discussion, a ballot was then taken on the admission of Miss Anita E. Tyng, as a Fellow of the Society, and she was elected by a vote of 24 yeas to 9 nays,

receiving more than the two-thirds vote required for admission.

Drs. Henry King, of Providence, J. M. Marchant, of Warren, Robert Miller, of Providence, were appointed by the President to read papers before the Society at the next quarterly meeting in March, 1873.

On motion, it was voted to hold the next meeting of the Society in Providence, at the same place, and the Secretary and Treasurer were instructed to provide a collation for that occasion, at the expense of the Society.

Dr. E. M. Snow moved that a special committee be appointed by the President to examine the by-laws, and obtain legal advice, if desirable, upon the question, whether, according to a strict construction of said By-Laws, all the new members admitted by ballot as Fellows of the Society at this meeting, were *legally* elected and entitled to all the rights and privileges of its membership, and report at the next meeting. The motion was adopted, and Dr. Snow appointed as said committee. On motion, the meeting was then adjourned to the third Wednesday in March, 1873, at 10 o'clock, A.M.

Medical and Surgical Journal.

BOSTON: THURSDAY, DECEMBER 26, 1872.

FIRE-PROOF BUILDINGS.

ALL the world knows the sad story, scarcely a month old, regarding the city which so many of us hold dear; and tens of thousands will retain to their dying hours a recollection of the awful sights which met them on those eventful days, when our entire city seemed doomed to destruction. We learned many lessons during those brief hours; we felt that we paid a bitter price to be taught that specimens of igneous rock, in the form of wall and pillar and cornice, were not proof against fire; and the name of the French architect still call up a shudder of insecurity as we remember the flames leaping from roof to roof.

But the fire has benefited us in some directions, and the secular journals give us numberless accounts of heroism, of energy and spirit, of trial and self-sacrifice, hither-

to latent, perhaps, which show the fire to have been by no means an unmixed evil.

An occasion of this kind calls to our minds the fact of insecurity of property in various directions, and we should not allow the horse, which remains, to be stolen for want of care in closing the stable door. Within a block of the spot where the fire was arrested is situated one of the finest professional museums in the country; at the medical college in North Grove Street—nearly surrounded by buildings of the poorest and most combustible character—is the valuable Warren Museum; both of them the result of professional work for years of the most eminent men of our neighborhood—both of them owing much of their importance to the life-long labors of one who is held by the profession universally with respect and regard. We call to mind the fact that Dr. Wigglesworth's Museum of Dermatology and Syphilography is situated in a very insecure building; and that numerous private collections are in positions where they are in constant danger of destruction.

It becomes, therefore, a serious question, and should engage the attention of wealthy members of the profession, both in Boston and elsewhere, whether the collections, to which we looked for instruction in our earlier days, and which may be the means of education to those who come after us, shall be allowed to remain in situations so hazardous.

Boston—thank God—needs no assistance, so far as the business resources of all classes of our population, from the highest to the lowest, are compromised; but the institutions of learning in our midst belong to the land, and, in their distress, all suffer. The circular letter of President Eliot informs us that Harvard University has been seriously crippled in all its departments, medical as well as academical, by the late fire. The medical school, which, in the cause of true medicine is striving to give better, more thorough and more scientific knowledge to the whole country, is embarrassed. Our valuable collections are to become the property of the school as soon as suitable buildings are provided for their

protection; but they are now liable at any time to be devoured by the flames. These are facts. We do not suggest any course of action to Harvard's prosperous alumni, wherever resident; such suggestions can easily be made by each one for himself.

THE EFFECTS OF HIGH ELEVATIONS ON THE SYSTEM.—According to Prof. Bert (*Jour. de Med. et Chir. Prat.*) modern biologists have wrongly attributed mountain-disease (*mal des montagnes*) to a too great proportion of carbonic acid dissolved in the blood. It is rather due to a deoxygenation which exists in proportion to the diminution of barometric pressure. Thus is confirmed the opinion of Jourdanet on the anæmic, or anoxymic condition of men inhabiting high regions, as the Mexican plateaus, where he made his observations.

Mr. Bert also examined the effects of increased barometric pressure, as endured by submerged bridge-builders, divers and pearl-fishers, and explained certain accidents common to such occupations, among others that of sudden paralysis following a rapid passing from very high to normal pressure.

An hypothesis of M. Bouchard, in his introductory thesis, has been justified by an experiment of M. Bert. It is quite possible, said M. Bouchard, that these accidents are due to a considerable disengagement of gas from the blood; as effervescence is caused in gaseous water on its return to normal pressure when the bottle is uncorked. The presence of gas in the blood was demonstrated by M. Bert as follows: a cat, submitted to a pressure of eight atmospheres and rapidly removed from it, was almost immediately struck with paraplegia. Autopsy disclosed a non-hæmorrhagic softening of the spinal marrow and gas in the bloodvessels.

A practical conclusion from these investigations of M. Bert, applicable to occupations pursued under high pressure, is to supply, not pure air, but a mixture of air and nitrogen, in such a manner as to suitably reduce the pressure of the oxygen.

THE SOURCE OF DEATH FROM POISONS.—In an article from the *Med. Times and Gaz.* Oct. 19, 1872, suggested by some recent cases of alleged poisoning, occurs the following:

"A very common mistake we often see reproduced at trials is that of saying 'enough poison was found in the stomach to account for death.' Very often, in cases

of poisoning, there is hardly any poison found in the stomach, and in many where it is found, has nothing to do with causing death. Take a case of poisoning by strychnine, for example; it is not the strychnine found in the stomach, but that which has been absorbed, and reached the nervous system, which has caused death. This is only partially true in the case of arsenic, but even here the fact ought not to be overlooked."

Correspondence.

VIVISECTION.—Messrs. Editors: The following forcible lines are extracted from an able and comprehensive paper on the "Consciousness of Animals" in the last British Quarterly Review and which occupies about eighteen pages of the December number of *Littell's Living Age*. H. J. B.

"Lastly, *faith* in a beloved superior is perhaps the most beautiful and affecting of all the attributes of a dog. Whose heart does not grow sick at the reflection that this sacred trust of the dog in man, should be so often betrayed,—that dull bores should lure him by mock words of encouragement to death (to him so slow and agonizing) of the halter; and that far worse wretches, in the guise of cultivated gentlemen, should first fondle, and then dissect him alive, while even in death he strives to show his confidence, and to lick their hands? Few of us, it is to be hoped, would purchase our own immunity from disease at the cost of scores of such cruel experiments, and the assurance of the vivisectors who perform them, that they do so wholly for our sakes, and not from mere scientific curiosity, would be laughable, could we find it in our hearts to laugh at such matter. It is surely time for the world to recognize that Science may be the Moloch of one age as Superstition was of another; and that even the noble love of knowledge may prompt offences, heinous and hateful as ever sprung from the lust of power or of gold.

"The princely motto 'Ich dien,' might justly be his, for he lives but to serve and obey to the utmost of his strength and intelligence.

"He grudges nothing for his master, resents nothing that he does to him, and trusts him even when, like the miserable French vivisector, he tries on him an 'expérience morale,' and tests how much torture he will bear before his love turns to fear and hate."

Medical Miscellany.

THE BIGELOW OPERATING CHAIR.—The surgeons of the Boston City Hospital are fortunate in having at last one of these incomparable chairs for their use in operations. Eight years ago, at the opening of the hospital, they were provided by the trustees with a common barber's chair. It was intended, however, that this should be replaced by a more satisfactory article at an early day. The chair which they are to use in the future was made by the same maker and of the same pattern as that so well known at the Massachusetts General Hospital. The original was designed by Dr. H. J. Bigelow, has been in constant use for the past 18 years, and, except a new covering, has never needed repair. Dr. Cheever, in showing the chair to the physicians and members of the medical class a few days ago, stated that it was, in his opinion, superior to any he had seen in the operating theatres in Europe.

"PALPATION IN OBSTETRICS AS PRACTISED IN GERMANY."—Under this title, Dr. Chadwick has published a highly interesting paper in the *Boston Medical and Surgical Journal* for August 15th and 22d. It is far too long for extract, and will not admit of abbreviation, consisting, as it does, of detailed instructions for the practice of palpation as witnessed by the author in Vienna and Würzburg clinics, where it has attained an importance unknown in other countries. The paper is of more interest because no detailed account of the procedure has been published even in the German midwifery works.

The above extract is taken from the *London Medical Times and Gazette* for Oct. 26th ult.

EIGHT CHILDREN AT A BIRTH.—Now that this item, accredited to this JOURNAL, has gone the rounds of the medical press in this country and abroad, and has elicited various comment with regard to the doubt of such a tremendous obstetrical feat, we are glad to send another item after the first to contradict the story, and to say that such a performance never occurred and that we never believed it did.

THE TRUSTEES OF "THE TONER LECTURES," Washington, D.C., have already completed arrangements with eminent medical gentlemen for the three first lectures under this trust. The first of the course will be delivered in February, 1873, by J. J. Woodward, M.D., U.S.A., at present in charge of the Army Medical Museum. The second will be delivered in April, 1873, by Prof. C. E. Brown-Séquard, M.D., and the third, some time in the fall or winter of 1873, by Prof. Alonzo Clarke, M.D., of New York.

MATTHEW VASSAR and John Guy Vassar have decided to invest \$100,000 in the founding of a hospital in Poughkeepsie, N. Y.

ALBANY HOSPITAL.—By the will of the late William H. DeWitt, the Albany Hospital receives ten thousand dollars.

CORRECTION.—On page 435 of the JOURNAL, second column, first line, for "during the past four years" read *during the past few years*. On page 396, first column, the statement in lines 25-28 was made by Dr. Johnson in regard to such cases in general, and not in reference to the six cases previously mentioned.

BOOKS RECEIVED.—*Physics and Politics; or Thoughts on the application of the Principles of "Natural Selection" and "Inheritance" to Political Society.* By Walter Bagshot, Esq. New York: D. Appleton & Co. 1872. Pp. 224. (From A. Williams & Co.)—*Surgical Diseases of Infants and Children.* By M. P. Guersant, Honorary Surgeon of the Hôpital des Enfants Malades, Paris, &c. Translated from the French by Richard J. Dunglison, M.D. Philadelphia: H. C. Lea. 1873. Pp. 354. (From the Publishers.)

PAMPHLETS RECEIVED.—*An Examination of Prof. Reese's "Review of the Trial of Mrs. Wharton for the Murder of Gen. Ketchum."* By Philip C. Williams, M.D. Baltimore, Md. 1872. Pp. 31.—*Transactions of the New Hampshire Medical Society (Eighty-second Anniversary) held at Concord, June 11 and 12, 1872.* Manchester, N. H., 1872. Pp. 96.—*Free Parks and Camping Grounds, Sanitariums for the Sick and Debilitated Children of large Cities during the Summer Months.* By J. M. Toner, M.D., Washington, D. C. Pp. 16.

DIED.—In Worcester, Dec. 7th, John Andrews, M.D., formerly of Boylston, 79.

Deaths in sixteen Cities and Towns of Massachusetts, for the week ending Dec. 14, 1872.

Cities and Towns.	No. of Deaths.	Newburyport	4
Boston	183	Somerville	5
Charlestown	15	Haverhill	3
Worcester	18	Holyoke	6
Lowell	14		335
Milford	4		
Chelsea	7		
Cambridge	24		
Salem	11		
Lawrence	8		
Springfield	7		
Lynn	13		
Fitchburg	3		

Prevalent Diseases.

Smallpox	70
Consumption	43
Pneumonia	26
Scarlet Fever	20
Typhoid Fever	16
Croup and Diphtheria .	7

The deaths from smallpox were as follows:—In Boston, fifty-one, Cambridge six, Charlestown five, Lynn three, Chelsea three, Lawrence one, Holyoke one. Of the deaths from scarlet fever eighteen were in Boston.

GEORGE DERRY, M.D.,
Secretary of State Board of Health.

DEATHS IN BOSTON for the week ending Saturday, December 21st, 186. Males, 109; females, 87. Accident, 6—asthma, 1—inflammation of the bowels, 2—disease of the bowels, 1—bronchitis, 4—disease of the brain, 5—cancer, 2—cerebro-spinal meningitis, 2—consumption, 24—convulsions, 4—croup, 2—debility, 1—diarrhoea, 2—dropsy, 2—dropsy of brain, 1—scarlet fever, 6—erysipelas, 1—typhoid fever, 4—bilious fever, 1—disease of heart, 7—infantile, 1—intemperance, 2—disease of kidney, 4—laryngitis, 1—disease of the liver, 2—congestion of the lungs, 3—inflammation of the lungs, 8—marasmus, 5—measles, 1—old age, 6—paralysis, 3—pleurisy, 1—puerperal disease, 2—premature birth, 1—peritonitis, 2—disease of the stomach, 1—smallpox, 63—tonsillitis, 1—ulcer, 1—unknown, 4.

Under 5 years of age, 48—between 5 and 20 years, 18—between 20 and 40 years, 71—between 40 and 60 years, 30—above 60 years, 29. Born in the United States, 109—Ireland, 56—other places, 31.

